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| Serious Transfusion Incident Reporting |
| Summary report for 1 July 2020 to 30 June 2021 (FY21) |
| OFFICIAL |

# Introduction

In this financial year, 33 health services provided 180 notifications. Of these events, nine were withdrawn by the health service and 14 excluded by expert review, giving 157 validated reports.

For FY21, there were 103 validated clinical reports and 54 validated procedural reports. When compared with previous years, clinical events were reported more frequently than procedural events over the past five years.

## Validated clinical reactions for FY21

* Acute transfusion reactions: 61, including:
  + Febrile non-haemolytic transfusion reaction: 25
  + Allergic/anaphylactic/anaphylactoid: 31
  + Acute haemolytic: 1
  + Hypotensive: 1
  + Other: 2
* Delayed haemolytic reactions: 7
* Delayed serologic reactions: 23
* Transfusion associated circulatory overload: 10
* Transfusion related acute lug injury: 1
* Transfusion associated dyspnoea: 1
* RhD isoimmunisation: 1

**Note:** Some reactions can be minimised by pre-transfusion assessment of the patient for risk factors and close monitoring of the patient during the transfusion, for example, TACO.

## Validated procedural events for FY21

* Wrong blood in tube: 17
* Near miss: 6
* Incorrect blood component transfused: 7
* RhD administration: 22
* Procedural – other: 3

**Note:** Correct patient identification is essential to several steps in the transfusion process. Incorrect or inadequate patient identification can lead to serious incidents.

## Key messages

| Area | Recommendation |
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| Patient identification | Correct patient identification is essential to several steps in the transfusion process. Incorrect or inadequate patient identification can lead to serious incidents.  All staff need to understand what positive patient identification is and how it is to be performed: that is, asking the patient to state their name and date of birth where possible to compare to ID band and any documentation. |
| Clinical | Always suspect a transfusion reaction in the initial investigation of patient deterioration in the setting of current or recent transfusion. Treatment of life-threatening signs and symptoms is the priority in this situation and investigations occur once the patient has been stabilised (case study 1 in full report).  Investigation of the reaction should include both clinical and laboratory components to eliminate possible reaction types. Clinical signs and symptoms alone may not help to eliminate all possible reaction types (case study 2 in full report).  Health services should use checklists to assist in assessment of patient risk of TACO or to step clinical staff through the bedside check. |
| Governance | As seen in STIR reports delayed serologic transfusion reactions occur regularly. Pathology providers may not share information on antibody history when a patient moves between health services. This puts the patient at risk of a reaction if a known antibody can no longer be recognised on testing. We recommend a national database to record patient red cell alloantibodies, which would assist laboratories to share information on patient antibody history.  Health services should ensure policies and procedures to prevent TA-GVHD are reviewed and up to date, and that these procedures decrease the risk of an at-risk patient receiving a non-irradiated product.  Health services should ensure policies and procedures for RhD immunoglobulin administration are in line with recently updated guidelines, and that staff are aware of the [guidelines](https://www.blood.gov.au/sites/default/files/Guideline%20for%20the%20prophylactic%20use%20of%20Rh%20D%20immunoglobulin%20in%20pregnancy%20care.pdf) and any changes in procedures <https://www.blood.gov.au/sites/default/files/Guideline for the prophylactic use of Rh D immunoglobulin in pregnancy care.pdf>).  Consider using electronic systems to identify patients and label specimens. These systems must have simple processes that cannot easily be overridden, in order to ensure safety mechanisms work (case study 12 in full report).  See [ANZSBT guidelines](https://anzsbt.org.au/guidelines-standards/anzsbt-guidelines/) <https://anzsbt.org.au/guidelines-standards/anzsbt-guidelines/> for further information on developing electronic medical records for transfusion. |
| Blood administration | Processes for collecting blood from blood fridges must be robust to ensure the correct product is collected each time. Identifiers must be taken to the fridge and checked at the time of collection, with the staff member documenting removal from storage (case study 8 in full report).  Positive patient identification is essential in several steps in the transfusion process. It is important staff are aware of the importance of correctly performing this task. They should involve the patient in the process, wherever possible, by asking them to state their name and date of birth. This is an opportunity to pick up errors in patient identification earlier in the process, for example errors in details on the wristband (case study 9 in full report). |

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